HAWAII STATE DEPARTMENT OF HEALTH

PEDIATRIC HIV INFECTION CASE REPORT (Patients <13 years of age at time of diagnosis)

If you have used this test code previously, please use the same names to create it again this time.

LAST NAME | **Date of Birth** (Month / Day / Year) | **FIRST NAME**

Detach and remove above this line

Confidential

Date form Completed: Mo. Day Yr.

Unnamed Test Code:

Month of Birth Helper:

Jan	01	Feb	02	Mar	03
Apr	04	May	05	Jun	06
Jul	07	Aug	08	Sep	09
Oct	10	Nov	11	Dec	12

I. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one)
[3] Perinatally HIV Exposed
[4] Confirmed HIV Infection (not AIDS) [6] Seroreverter
Mo. Yr.

Was reason for initial HIV evaluation due to clinical signs and symptoms? Yes [1] No [0] Unk. [9]

AGE AT DIAGNOSIS: HIV Infection (not AIDS) ..... Years Months

CURRENT STATUS: [1] Alive [2] Dead [9] Unk.

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH:

DATE OF INITIAL EVALUATION FOR HIV INFECTION: Mo. Yr.

SEX: [1] Male [2] Female

RACE/ETHNICITY: [1] White (not Hispanic) [2] Black (not Hispanic) [3] Hispanic [4] Asian/Pacific Islander: [Hawaiian] [Japanese] [Filipino] [Chinese] [Other] Specify: [5] American Indian/ Alaska Native [9] Not Specified

COUNTRY OF BIRTH: [1] U.S. [7] U.S. Dependencies and Possessions (including Puerto Rico) (specify): [8] Other (specify): [9] Unk.

RESIDENCE AT DIAGNOSIS:
City: County: State/Country: Zip Code:

II. PATIENT/MATERNAL HISTORY (*Respond to ALL Categories*)

- **Child's biologic mother's HIV Infection Status:** (check one)

[1] Refused HIV testing
[2] Known to be uninfected after this child's birth
[9] HIV status unknown

Diagnosed with HIV Infection:

[3] Before this child's pregnancy
[5] At time of delivery
[7] After the child's birth
[4] During this child's pregnancy
[6] Before child's birth, exact period unknown
[8] HIV-Infected, unknown when diagnosed

- **Date of mother's first positive HIV confirmatory test:** ..... Mo. Yr.

- **Mother was counseled about HIV testing during this pregnancy, labor or delivery?** ..... Yes [1] No [0] Unk. [9]

After 1977, this child's biologic mother had:

	Yes	No	Unk.
• Injected nonprescription drugs	1	0	9
• *HETEROSEXUAL* relations with:			
- Intravenous/injection drug user	1	0	9
- Bisexual male	1	0	9
- Male with hemophilia/coagulation disorder	1	0	9
- Transfusion recipient with documented HIV infection	1	0	9
- Transplant recipient with documented HIV infection	1	0	9
- Male with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion or blood/blood components (other than clotting factor)	1	0	9
• Received transplant of tissue/organs or artificial insemination	1	0	9

Before the diagnosis of HIV infection, this child had:

	Yes	No	Unk.
• Received clotting factor for hemophilia/coagulation disorder	1	0	9
(specify disorder): [1] Factor VIII (Hemophilia A) [2] Factor IX (Hemophilia B) [8] Other (specify):			
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
First: Mo. Yr. Last: Mo. Yr.			
• Received transplants of tissue/organs	1	0	9
• Sexual contact with a male	1	0	9
• Sexual contact with a female	1	0	9
• Injected nonprescription drugs	1	0	9
• Other (Alert State/City NIR Coordinator)	1	0	9

III. BIRTH HISTORY (for PERINATAL cases only)

Birth history was available for this child: [1] Yes [0] No [9] Unk. ***If NO or Unknown, proceed to Section IV.***

HOSPITAL AT BIRTH:

Hospital: _____ City: _____ State: _____ Country: _____

RESIDENCE AT BIRTH:

City: _____ County: _____ State/ Country: _____ Zip Code: [ ][ ][ ][ ][ ] [ ][ ][ ][ ]

BIRTHWEIGHT: (enter lbs/oz OR grams)

[ ][ ] lbs. [ ][ ] oz.

[ ][ ][ ][ ] grams

BIRTH: Type ..... [1] Single [2] Twin [3] >2 [9] Unk.

Delivery: ..... [1] Vaginal [2] Elective Caesarean [9] Unk.
[3] Non-elective Caesarean [4] Caesarean, unk. type

Birth Defects: ..... [1] Yes [0] No [9] Unk.

Specify type(s): _____ Code: [ ][ ][ ].[ ][ ][ ]

NEONATAL STATUS:

[1] Full term

[2] Premature

Weeks [ ][ ] 99=Unk.

PRENATAL CARE:

Month of pregnancy prenatal care began: MOS. [ ][ ] 99=Unk. 00=None

Total number of prental care visits: [ ][ ] 99=Unk. 00=None

- **Did mother receive zidovudine (ZDV, AZT) during pregnancy?** Refuse [8] Yes [1] No [0] Unk. [9]
- **If yes, what week of pregnancy was zidovudine (ZDV, AZT) started?** Weeks [ ][ ] 99=Unk.
- **Did mother receive zidovudine (ZDV, AZT) during labor/delivery?** Refused [8] Yes [1] No [0] Unk. [9]
- **Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy?** Yes [1] No [0] Unk. [9]
- **Did mother receive any other Anti-retroviral medication during pregnancy** Yes [1] No [0] Unk. [9]
  If yes, specify: _____
- **Did mother receive any other Anti-retroviral medication during labor/delivery?** Yes [1] No [0] Unk. [9]
  If yes, specify: _____

Birthplace of Biologic Mother:

[1] U.S. [7] U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____

[8] Other (specify): _____ [9] Unk.

Maternal Date of Birth Mo. [ ][ ] Day [ ][ ] Yr. [ ][ ]

This report to the Department of Health is required by §325-2, Hawaii Revised Statutes (HRS) and §11-156-8.8, Hawaii Administrative Rules. Your cooperation is necessary for the understanding and control of HIV/AIDS. The confidentiality of all information submitted is protected by Chapter 92F and §325-101, HRS.

IV. FACILITY OF DIAGNOSIS

Facility Name: _____ City: _____ State/ Country: _____

FACILITY SETTING (check one)

[1] Public [2] Private [3] Federal [9] Unk.

FACILITY TYPE (check one)

[01] Physician, HMO [31] Hospital, Inpatient [88] Other (specify): _____

Physician's Name: _____ Phone No.:( )_____ Medical Record No.:_____
(Last, First, M.I.)

Hospital/Facility: _____ Person Completing Form: _____ Phone No.:( )_____

V. LABORATORY DATA

1. HIV ANTIBODY TEST AT DIAGNOSIS: (Record all tests, include earliest positive)

	Positive	Negative	Indeterminate	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV-1 EIA	1	0	—	9		
• HIV-1 EIA	1	0	—	9		
• HIV-1/HIV-2 combination EIA	1	0	—	9		
• HIV-1/HIV-2 combination EIA	1	0	—	9		
• HIV-1 Western blot/IFA	1	0	8	9		
• HIV-1 Western blot/IFA	1	0	8	9		
• Other HIV antibody test (specify): _____	1	0	8	9		

2. HIV DETECTION TEST:
(Record all tests, include earliest positive)

	Pos	Neg	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV culture	1	0	9		
• HIV culture	1	0	9		
• HIV antigen test	1	0	9		
• HIV antigen test	1	0	9		

	Pos	Neg	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV DNA PCR	1	0	9		
• HIV DNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• Other, specify _____	1	0	9		

3. HIV VIRAL LOAD TEST: Record all tests, include earliest detectable **(Voluntary)**

•Type: 11, NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA (Chiron) 18. Other

Test type*	Detectable Yes	Detectable No	COPIES/ML	TEST DATE Mo.	TEST DATE Yr.
			, ,		
	1	0	, ,		

4. IMMUNOLOGICAL LAB TEST: (At or closest to current diagnostic status)
(Voluntary)

		Mo.	Yr.
• CD4 Count	, cells/μL		
• CD4 Count	, cells/μL		
• CD4 Percent	%		
• CD4 Percent	%		

5. Did the patient test HIV+ in another state? 1 Yes 0 No 9 Unk.
If yes, please give state name: _____ Date of test: Mo. Yr.

6. If laboratory tests were not documented, is patient confirmed by a physician as:

	Yes	No	Unk.	Date of Documentation Mo.	Date of Documentation Yr.
• HIV-infected	1	0	9		
• Not HIV-infected	1	0	9		

VI. TREATMENT SERVICES REFERRALS

This child received or is receiving:

	Yes	No	Unk.	DATE STARTED Mo.	DATE STARTED Day	DATE STARTED Yr.
• Neonatal zidovudine (ZDV, AZT) for HIV *prevention*	1	0	9			
• Other neonatal anti-retroviral medication for HIV *prevention*	1	0	9			
If yes, specify: _____						

	Yes	No	Unk.	DATE STARTED Mo.	DATE STARTED Day	DATE STARTED Yr.
• Anti-retroviral therapy for HIV *treatment*	1	0	9			
• PCP prophylaxis	1	0	9			

Was child breast fed? 1 Yes 0 No 9 Unk.

This child has been enrolled at:

Clinical Trail: 1 NIH-sponsored 2 Other 3 None 9 Unk.

Clinic: 1 HRSA-sponsored 2 Other 3 None 9 Unk.

This child's treatment is primarily reimbursed by:

1 Medicaid 4 Other Public Funding
2 Private insurance/HMO 7 Clinical trail/government program
3 No coverage 9 Unk.

This child's primary caretaker is:

1 Biologic Parent(s) 2 Other relative 3 Foster/Adoptive parent, relative 4 Foster/Adoptive parent, unrelated 7 Social service agency 8 Other (specify in Section VIII.) 9 Unk.

VII. REQUESTED INFORMATION

• Does this patient have symptomatic AIDS or CD4 count <200 cells/μL or <14%? Yes 1 No 0

If yes, please attach an AIDS case report form and write down the patient's name, date of birth and Section VIII (AIDS indicator disease) and/or CD4 count.

For Official Use Only: 1 New Report 0 Update

Case No: _____

VIII. COMMENTS

RACE/ETHNIC BACKGROUND FORM

1. ETHNICITY: *(Please select one)*

1	Hispanic	2	Not Hispanic or Latino	9	Unknown

2. RACE: *(Please select one or more)*

	White		Black or African American		Unknown
	Asian		Native Hawaiian or Other Pacific Islander		

3. FOR ASIANS OR HAWAIIAN/ PACIFIC ISLANDERS

(Please select one or more)

ASIANS:		HAWAIIAN / PACIFIC ISLANDERS:	
01	Japanese	04	Hawaiian
02	Filipino	07	Samoan
03	Chinese	08	Guamanian
06	Korean	09	Tongan
17	Vietnamese	10	Fijian
18	Laotian	11	Marshallese
19	Thai	12	Micronesian
20	Cambodian	13	Tahitian
21	Indonesian	14	Northern Mariana
22	Asian Indian	15	Palauan
23	Other Asian	16	Other Pac. Islander
24	Pakistani	26	Polynesian
25	Malaysian		